ALABAMA MEDICAID AGENCY
WAIVER MEDICAL FORM/
WAIVER SLOT CONFIRMATION FORM

Client's Name _____

Client's Address _____

Social Security Number _____

Operating Agency _____

Name of Waiver _____

Waiver Slot Available Yes ____ No ____ Date _____

Level of Care Approved Yes ____ No ____ Date _____

Disability Determination Required *Yes ____ No ____ Onset Disability _____

Waiver Transitional Medicaid Transitioning from Nursing Home? Yes ____ No _____

Date of Discharge from Nursing Facility _____

Start Date of Waiver Services _____

Name/Address of Nursing Facility _____

_____

Transferring from Another Waiver? Yes ____ No ____ Date of Transfer _____

Name of Waiver Transferring from _____

Signature and Title of Reviewer _____

Phone Number of Reviewer (_____)_____

Name and Fax Number for Award Notification _____

District Office _____

Fax Number of District Office (_____)_____

Date Application Mailed to District Office _____

NOTE: LTC ADMISSION NOTIFICATION FORM SHOULD NOT BE TRANSMITTED UNTIL FINANCIAL ELIGIBILITY IS ESTABLISHED.

*If this is an adoption subsidy recipient, a disability determination is required. Please route packet directly to AMA Medical and Quality Review Services Unit. All other disability determinations should be sent to the appropriate District Office.